STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155665	A. BUILDING -- B. WING	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date(s): 07/25/22 & 07/26/22 Facility Number: 010996 Provider Number: 155665 AIM Number: 200232210 At this Emergency Preparedness survey, Majestic Care of North Vernon was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 120 certified beds. At the time of the survey, the census was 102. Quality Review completed on 07/28/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of correction. The provider alleges compliance as of 7/25/22** ="" b="">	
E 0024 SS=F Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for	E 0024	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of**	08/12/2022

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	integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Manual" documentation dated 04/15/22 with the Administrator and the Maintenance Supervisor during record review from 9:40 a.m. to 12:50 p.m. on 07/25/22, the emergency preparedness plan for the facility did not include the use of volunteers in an emergency or other emergency staffing strategies. Based on interview at the time of record review, the Administrator agreed the emergency preparedness documentation did not include a policy for the use of volunteers. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of correction. The provider alleges compliance as of 8/12/22** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. The policy will be revised to meet the criteria and guidance set forth by the life safety regulation 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.1. All Residents have the potential to be affected by this practice.2. The Maintenance Director was educated on the policy related to the alleged deficient practice 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.1. The Maintenance Director/designee will provide education the Majestic Care of North Vernon employees 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.1. For quality	

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			assurance, the Maintenance Director/designee will review any findings yearly, with subsequent corrective action and education for identified staff.2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-12-2022	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing			

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	structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.			

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	(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include:	E 0041	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of**	08/12/2022

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	a. Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generators: Test Generator Under Load" documentation for the most recent twelve month period with the Maintenance Supervisor during record review from 9:40 a.m. to 12:50 p.m. on 07/25/22, monthly load testing documentation for the facility's diesel fired emergency generator for the six month period of August 2021 through January 2022 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated he started working at the facility earlier in 2022 and agreed monthly load testing documentation for the aforementioned six month period was not available for review. b. Based on review of Direct Supply TELS Logbook Documentation "Emergency Generators: Exercise Generator (with no load)" documentation for the most recent 52 week period with the Maintenance Supervisor during record review from 9:40 a.m. to 12:50 p.m. on 07/25/22, weekly inspection documentation for the facility's diesel fired emergency generator for the 31 week period of 08/21/21 through 03/25/22 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated he started working at the facility earlier in 2022 and agreed weekly generator inspection documentation for the aforementioned 31 week period was not available for review. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**Credible Allegation & request a desk review regarding plan of correction. The provider alleges compliance as of 8/12/22** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.1. All residents have the potential to be affected by the alleged deficient practice. Facility generator has been tested “under load” and” with no load”. Facility generator met requirements during testing2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.1. All Residents have the potential to be affected by this practice.2. The Maintenance Director was educated on the regulation of all facility generator testing and documenting in TELs 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.1. The Maintenance Director/designee will audit weekly that all documentation and testing of the facility generator is completed in accordance with state and federal regulations 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be	

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			put into place.1. For quality assurance, the Maintenance Director/designee will review any findings yearly, with subsequent corrective action and education for identified staff.2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-12-2022	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a) which resulted in Immediate Jeopardy. Immediate Jeopardy cited at K211 and K222 Survey Date(s): 07/25/22 & 07/26/22 Facility Number: 010996 Provider Number: 155665 AIM Number: 200232210 At this Life Safety Code survey, Majestic Care of North Vernon was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke	K 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of correction. The provider alleges compliance as of 7/25/22** ="" b="">	

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	detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. All 61 resident sleeping rooms were surveyed except for Rooms A100 through A104 due to Covid-19 concerns. The facility has a capacity of 120 and had a census of 102 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 07/28/22			
K 0211 SS=K Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 1. Based on observation and interview, the facility failed to maintain the means of egress free from obstructions in 1 of 8 means of egress. This deficient practice could affect 8 residents, staff and visitors if needing to exit the facility by Room A100. This deficiency resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 07/25/22 at 3:05 p.m. when it was observed that the exit door to the outside of the facility by Room A100 did not release to open with fire alarm system activation at 3:05 p.m. The Immediate Jeopardy started on 07/23/22, based on statements by the Maintenance Supervisor, when	K 0211	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of correction. The provider alleges compliance as of 8/12/22**	08/12/2022

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	the fire alarm system inspection contractor installed a new replacement keypad at the exit door to the outside of the facility by Room A100 but did not complete the installation of the keypad leaving the new keypad inoperable. In the event of an actual fire, the exit door had no means to release the door to open with the keypad not being operable and the door not releasing to open with fire alarm system activation. The Immediate Jeopardy was removed on 07/26/22 at 2:00 p.m. when the surveyor conducted a revisit following notification that the fire alarm system contractor completed keypad installation and all necessary repairs for the door to release to open upon fire alarm system activation during the evening of 07/25/22. The surveyor reviewed "Work Performed" documentation dated 07/25/22 from the fire alarm system inspection contractor indicating a new keypad was installed on 07/25/22 and the mag lock for the exit door was rewired and tested the fire alarm system to ensure the door would release to open with fire alarm system activation. Surveyor observed on 07/26/22 the new keypad did release the door to open. Findings include: Based on observations with the Maintenance Supervisor during the initial walk through of the facility from 9:25 a.m. to 9:40 a.m. on 07/25/22, the exit door to the outside of the facility by Room A100 was marked as a facility exit with an exit sign and was also marked as a delayed egress door with the necessary signage stating the door could be released to open after pushing for 15 seconds. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:05 p.m., the delayed egress door to the outside of the facility by Room A100 failed to		1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. All residents have the potential to be affected by the alleged deficient practice 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this alleged deficient practice. 2. A campus wide review was completed to ensure no other obstructions were in the way of a means of egress 3. A campus wide review was completed of all exit doors 4. The Maintenance Director was educated on the regulation of keeping hallways and egresses free of obstructions & on means of egress regulations 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.	

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	release to open after pushing on the door for 15 seconds multiple times. The door also had a keypad at the exit door to release the door to open but the code to release the door to open was not posted at the exit door. In addition, the front cover portion of the keypad was partially disconnected from the portion of the keypad affixed to the wall and the keypad appeared to have no electrical power. The keypad was inoperable. The Maintenance Supervisor stated the fire alarm inspection contractor installed a new keypad on Saturday (07/23/22) and was scheduled to complete repairs for the keypad installation this coming Wednesday (07/27/22). The Maintenance Supervisor stated the door is also supposed to release to open with fire alarm system activation. Based on observations at 3:05 p.m. on 07/25/22, the Maintenance Supervisor activated the fire alarm system at 3:05 p.m. by activating a manual pull station by the exit door by Room A100. The exit door failed to release to open with fire alarm system activation. Based on interview at the time of the observations, the Maintenance Supervisor stated the exit door should have released to open with fire alarm system activation and contacted the fire alarm system contractor who stated they were in route for the repairs. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the means of egress free from obstructions in 2 of 8 means of egress. This deficient practice could affect over 20 residents, staff and visitors.		1. The facility Maintenance Director/designee will complete a 100% audit 5 times a week for 3 months during his rounding of the East and West buildings to ensure hallways and common areas are free of obstructions. 2. The facility Maintenance Director/designee will complete a 100% audit 5 times a week ongoing of facility fire egress doors **4.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-12-2022	

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	Findings include: Based on observations with the Maintenance Supervisor during the initial walk through of the facility from 9:25 a.m. to 9:40 a.m. on 07/25/22, a large, padded wheelchair was stored in the corridor outside Room D101 and blocked nearly half of the eight-foot-wide corridor. In addition, one large stainless steel meal serving cart, a cart with cardboard boxes and seven oxygen concentrators were stored in the corridor outside the kitchen near the exit door of the facility by the oxygen storage and transfilling room. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:05 p.m., the large, padded wheelchair was still stored in the corridor outside Room D101, and all items stored in the corridor outside the oxygen storage and transfilling room were still stored in the corridor. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned means of egress were not continuously maintained free of all obstructions to full use in case of emergency. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0222 SS=K Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/26/2022

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	LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			

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	155665	A. BUILDING 01 B. WING	07/26/2022

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	ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 1. Based on observation and interview, the facility failed to ensure 1 of 6 exit doors to the outside of the facility in a required means of egress were arranged to unlock the door upon fire alarm system activation. This deficient practice could affect 8 residents, staff and visitors if needing to exit the facility by Room A100. This deficiency resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 07/25/22 at 3:05 p.m. when it was observed that the exit door to the outside of the facility by Room A100 did not release to open with fire alarm system activation at 3:05 p.m. The Immediate Jeopardy started on 07/23/22, based on statements by the Maintenance Supervisor, when the fire alarm system inspection contractor installed a new replacement keypad at the exit door to the outside of the facility by Room A100 but did not complete the installation of the keypad leaving the new keypad inoperable. In the event of an actual fire, the exit door had no means to release the door to open with the keypad not being operable and the door not releasing to open	K 0222	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of correction. The provider alleges compliance as of 8/12/22** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	08/12/2022

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	155665	A. BUILDING 01 B. WING	07/26/2022

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	with fire alarm system activation. The Immediate Jeopardy was removed on 07/26/22 at 2:00 p.m. when the surveyor conducted a revisit following notification that the fire alarm system contractor completed keypad installation and all necessary repairs for the door to release to open upon fire alarm system activation during the evening of 07/25/22. The surveyor reviewed "Work Performed" documentation dated 07/25/22 from the fire alarm system inspection contractor indicating a new keypad was installed on 07/25/22 and the mag lock for the exit door was rewired and tested the fire alarm system to ensure the door would release to open with fire alarm system activation. Surveyor observed on 07/26/22 the new keypad did release the door to open. Findings include: Based on observation at 3:05 p.m. on 07/25/22, the Maintenance Supervisor activated the fire alarm system at 3:05 p.m. by activating a manual pull station by the exit door by Room A100. The exit door failed to release to open with fire alarm system activation. Based on interview at the time of the observations, the Maintenance Supervisor stated the exit door should have released to open with fire alarm system activation and contacted the fire alarm system contractor who stated they were en route for the repairs. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of		1. All residents and visitors have the potential to be affected. 2. The egress door near room A100 that resulted in immediate jeopardy was corrected immediately 3. The signage on the exit door in the main lobby entrance was removed, because the door is not a delayed egress 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.1. All Residents have the potential to be affected by this practice.2. A campus wide audit was done on all egress doors to ensure functionality3. Maintenance Director was educated on the regulation of means of egress and delayed egress doorways 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.1. The facility Maintenance Director/designee will complete a 100% audit 5 times a week for 3 months on egress doors to ensure functionality and that facility is in compliance with state & federal regulations 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.1. For quality assurance, the Maintenance	

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	5 delayed egress locks were readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS.		Director/designee will review any findings daily, with subsequent corrective action and education for identified staff.2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined.5. Date of Compliance: 8-12-2022	

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	155665	A. BUILDING 01 B. WING	07/26/2022

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	DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility from the main entrance lobby. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:30 p.m. on 07/25/22, the exit door in the main entrance lobby was marked as a facility exit with an exit sign. The door was magnetically locked and could be released by entering a four digit code which was posted at the exit door set to release the doors to open. The exit door set was also equipped with delayed egress signage stating the doors would release to open after 15 seconds but the doors failed to release to open after pushing for more than 15 seconds multiple times. Based on interview at the time of the observations, the Maintenance Supervisor stated he was not certain the door was still arranged as delayed egress door but agreed the door was equipped with delayed egress signage and would not release to open after pushing for 15 seconds multiple times. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in			

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	155665	A. BUILDING 01 B. WING	07/26/2022

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	accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 2 of over 14 hazardous areas such as fuel-fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance	K 0321	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of**	08/12/2022

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	Supervisor during a tour of the facility from 12:50 p.m. to 3:30 p.m. on 07/25/22, a one- and one-half foot square hole was noted in the ceiling of the water softener room by the kitchen which exposed the attic above. Five pipes and conduits penetrated the opening. Two layers of 5/8ths inch thick drywall was noted for the ceiling in the room. In addition, a one-foot square hole was noted in the ceiling of the sprinkler riser room directly above the two-wall mounted electrical panels in the room. Two layers of 5/8ths inch thick drywall was also noted for ceiling of the riser room. Both rooms contained natural gas fuel-fired equipment. Based on interview at the time of the observations, the Maintenance Supervisor stated the water softener was replaced last week which the cause of the hole in the ceiling for that room but agreed the openings in the ceiling of the aforementioned rooms did not separate these hazardous areas from other spaces with smoke resistant partitions and doors. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**correction. The provider alleges compliance as of 8/12/22** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The one- and one-half foot score hole in the ceiling of the water softener room by the kitchen exposing the attic was repaired by the maintenance director. In addition, the one-foot square hole was noted in the ceiling of the sprinkler riser room above the electric panel was repaired by the maintenance director. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. The deficient practice could affect over 20 residents, staff, and visitors A campus wide audit was completed to ensure all hazardous areas had correct fire barriers in place Maintenance Director was educated on the regulation of ensuring all necessary barriers are established between hazardous areas What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.	

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	155665	A. BUILDING 01 B. WING	07/26/2022

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			Maintenance Director/designee will complete a 100% audit 5 times a week for 3 months during rounding to ensure all proper barriers are within accordance with state and federal regulation related to hazardous areas How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. Date of Compliance: 8-12-2022	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments			

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	155665	A. BUILDING 01 B. WING	07/26/2022

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	with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen fire suppression systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect over three staff and visitors in the kitchen. Findings include: Based on review of the kitchen fire suppression system inspection contractor's inspection documentation dated 05/20/21 and 05/12/22 with the Maintenance Supervisor during record review from 9:40 a.m. to 12:50 p.m. on 07/25/22, documentation of semiannual fire suppression system inspection six months after 05/20/21 was not available for review. The kitchen fire suppression system inspection contractor also provided "Kitchen Suppression System Inspection documentation dated 11/04/22 but it could not be determined during the survey if the report should have been dated 11/04/21. Based	K 0324	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of correction. The provider alleges compliance as of 8/12/22** 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1.All residents have the potential to be affected by the alleged deficient practice. The facility dietary employees were re-educated on how to extinguish Grease Fires in the kitchen. Also, the kitchen fire suppression system was inspected and passed inspection	08/12/2022

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	155665	A. BUILDING 01 B. WING	07/26/2022

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	on interview at the time of record review, the Maintenance Supervisor stated he started working at the facility earlier in 2022, he did not know if the 11/04/22 inspection report should have been dated 11/04/21 and agreed documentation of semiannual fire suppression system inspection six months after 05/20/21 was not available for review. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1.All Residents have the potential to be affected by this practice. 2.The facility dietary employees were re-educated on how to extinguish Grease Fires in the kitchen. Also, the kitchen fire suppression system was inspected and passed inspection 3.Maintenance Director was educated on the regulation of ensuring dietary staff are educated regarding extinguishing grease fires and also ensuring that the range hood extinguishing system nozzles are positioned over the cooking equipment. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1.Maintenance Director/designee will complete a 100% audit 5 times a week for 3 months during his rounding of the kitchen to ensure the kitchen fire suppression system has proper functionality and is in accordance with the state and federal regulation How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.	

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			1.For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2.Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. Date of Compliance: 8-12-2022	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm System	K 0345	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of correction. The provider alleges compliance as of 8/12/22**	08/12/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

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	Inspection" documentation dated 05/10/22 with the Maintenance Supervisor during record review from 9:40 a.m. to 12:50 p.m. on 07/25/22, the main fire alarm system control panel batteries need replacement. The "Battery Results" section of the 05/10/22 inspection report stated "Fail" for both main fire alarm control panel batteries. Battery replacement documentation on or after 05/10/22 was not available for review. Based on interview at the time of the observations, the Maintenance Supervisor stated he was unaware the batteries failed inspection and testing on 05/10/22 because page 1 of 9 of the 05/10/22 report stated "All tested devices worked properly" but agreed battery replacement documentation on or after 05/10/22 was not available for review. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:30 p.m. on 07/25/22, the main fire alarm control panel is located near the nurse's station at the entrance to the B Hall. The batteries in the panel had a date code printed on each battery but it could not be determined if the date code for the batteries indicated they were replaced on or after 05/10/22. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All residents have the potential to be affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All Residents have the potential to be affected by this practice. The fire alarm testing system was tested and met requirements set forth by state and federal regulations What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Maintenance Director/designee will complete a 100% audit 5 times a week for 3 months during his rounding of the campus to ensure functionality and operability of the fire alarm testing system How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. For quality assurance, the Administrator/designee will review any findings yearly, with subsequent corrective action and education for identified staff. Findings will be reported at the QA meeting monthly or until	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/26/2022

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			substantial compliance has been determined. Date of Compliance: 8-12-2022	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 16 portable fire extinguishers were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.2.2(1) states inspection procedures shall verify that operating instructions on fire extinguisher nameplates are legible and face outward. This deficient practice could affect 10 residents, staff and visitors in the vicinity of Room D106. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:30 p.m. on 07/25/22, the portable fire extinguisher located in the wall mounted cabinet in the corridor by Room D106 was positioned in the cabinet such that the operating instructions and the pressure gauge for the extinguisher were facing toward the back wall of the cabinet. Based on interview at the time of observation, the Maintenance Supervisor agreed the fire extinguisher was not positioned in the cabinet with the operating instructions and pressure gauge for the extinguisher facing outward. This finding was reviewed with the Administrator	K 0355	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of correction. The provider alleges compliance as of 8/12/22** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. This deficient practice has the potential to affect 10 residents, staff, and visitors. 2. A campus wide audit was completed to ensure all facility fire extinguishers were positioned in	08/12/2022

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	and the Maintenance Supervisor during the exit conference. 3.1-19(b)		the cabinet such that the operating instructions and the pressure gauge for the extinguisher were positioned correctly facing forward. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. A campus wide audit was completed to ensure that all facility fire extinguishers were correctly positioned in cabinet as in accordance with state and federal regulations 3. The Maintenance Director was educated on the regulation of ensuring all fire extinguishers are positioned correctly in cabinets throughout the campus 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The Maintenance Director/designee will complete a 100% audit monthly for 3 months during daily rounding to ensure proper placement of fire	

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			extinguishers 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-12-2022	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not			

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	apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by the kitchen. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:30 p.m. on 07/25/22, the latching	K 0363	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of correction. The provider**	08/12/2022

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	mechanism for the corridor entry door to the oxygen storage and transfilling room near the kitchen failed to latch the door into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Supervisor agreed the corridor door to the oxygen storage and transfilling room failed to latch into the door frame. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**alleges compliance as of 8/12/22** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. The doors of concern during the survey have been readjusted and latch positively into their respective door frames. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by the alleged deficient practice. 2. A campus wide audit was completed to ensure all facility doors latch positively into their respective door frames. 3. The Maintenance Director was educated on the regulation of having all facility doors latch positively into their respective door frames. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.	

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			1. Maintenance Director/designee will complete a 100% audit 2 times a week for 3 months during his rounding of the East and West buildings to ensure that all facility doors latch positively into their respective door frames. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-12-2022	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an			

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	atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. 1. Based on record review, observation and interview; the facility failed to ensure 1 of 6 smoke barrier walls were protected to maintain the fire resistance of the smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 50 residents, staff and visitors in the vicinity of the corridor door set by Room C101. Findings include: Based on review of facility blueprint documentation with the Maintenance Supervisor during record review from 9:40 a.m. to 12:50 p.m. on 07/25/22, 2-hour fire resistance rated smoke barrier walls are constructed near Room B113, C101 and D115. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:30 p.m. on 07/25/22, a three inch in diameter hole for the passage of black and blue cables was noted in the attic smoke barrier wall above the corridor door set by Room C101 and was not firestopped. Fire resistance rating labels affixed to the hinge side of each corridor door in the door set by Room C101 indicated the door was 90-minute fire resistance rated and each door self-closed and latched into the door frame when tested to close. Based on interview at the time of the observations, the Maintenance Supervisor agreed the	K 0372	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of correction. The provider alleges compliance as of 8/12/22** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. All residents have the potential to be affected by the alleged deficient practice. All facility smoke barriers were audited to ensure compliance with state and federal regulations were met 2. How other residents having the potential to be affected by the same deficient practice will be	08/12/2022

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	aforementioned opening in the attic smoke barrier wall was not protected to maintain the fire resistance of the smoke barrier. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:30 p.m. on 07/25/22, a one- and one-half foot square hole was noted in the ceiling of the water softener room by the kitchen which exposed the attic above. Five pipes and conduits penetrated the opening. Two layers of 5/8ths inch thick drywall was noted for the ceiling in the room. In addition, a one-foot square hole was noted in		identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. A campus wide audit was completed of all facility smoke barriers to ensure compliance with state and federal regulatory requirements 3. The Maintenance Director was educated on regulatory requirements of smoke barriers 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The Maintenance Director/designee will inspect all smoke barriers throughout the facility 5 times a week for 3 months to ensure regulatory requirements are met related to smoke barriers 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. For quality assurance, the Maintenance Director/designee will review any findings yearly, with	

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	the ceiling of the sprinkler riser room directly above two wall mounted electrical panels in the room. Two layers of 5/8ths inch thick drywall was also noted for ceiling of the riser room. Based on interview at the time of the observations, the Maintenance Supervisor stated the water softener was replaced last week which was the cause of the hole in the ceiling for that room but agreed the aforementioned holes in the ceiling smoke barrier were not protected to maintain the fire resistance rating of the ceiling smoke barrier. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-12-2022	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to document quarterly fire drills or staff training documentation on fire drill procedures on the first shift for 1 of 4 quarters and on the second and third shifts for 2 of 4 quarters. LSC Section 19.7.1.6 requires drills to be conducted quarterly on each shift under varied	K 0712	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of**	08/12/2022

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	155665	A. BUILDING 01 B. WING	07/26/2022

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	conditions. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire Drill Report" and Direct Supply TELS "Logbook Documentation: Perform a Fire Drill" documentation with the Maintenance Supervisor during record review from 9:40 a.m. to 12:50 p.m. on 07/25/22, documentation of a first shift fire drill or staff training documentation on fire drill procedures on the first, second and third shift in the fourth quarter (October, November, December) 2021 was not available for review. In addition, documentation of a second shift and third shift fire drill or staff training documentation on fire drill procedures on the second and third shift in the third quarter (July, August, September) 2021 was also not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated the facility operates three shifts per day and agreed documentation of a fire drill or staff training on fire drill procedures for the aforementioned shifts and quarters in 2021 was not available for review. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to document the staff who participated in quarterly fire drills or staff training documentation on fire drill procedures on the second shift for 2 of 4 quarters and on the third shift for 1 of 4 quarters. LSC Section 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. LSC Section		**regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of correction. The provider alleges compliance as of 8/12/22** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. All facility residents have the potential to be affected by the alleged deficient practice. Moving forward from our Plan of Correction date the facility will be conducting fire drills per shift quarterly per regulation.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.1. All Residents have the potential to be affected by this practice.2. Moving forward from our Plan of Correction date the facility will be conducting fire drills per shift quarterly per regulation.3. The Maintenance Director was educated on the regulation of having a fire drill per shift per calendar quarter.3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	

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	19.7.1.8 states employees of health care occupancies shall be instructed in life safety procedures and devices. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire Drill Report" and Direct Supply TELS "Logbook Documentation: Perform a Fire Drill" documentation with the Maintenance Supervisor during record review from 9:40 a.m. to 12:50 p.m. on 07/25/22, documentation of the staff who participated in the fire drill or staff training documentation on fire drill procedures on the second shift in the first quarter (January, February, March) 2022 and the second quarter (April, May, June) 2022 was not available for review. Documentation for the second shift fire drill conducted on 03/08/22 at 8:00 p.m. and on 05/24/22 at 3:30 p.m. each did not include documentation of the staff who participated in the fire drill or drill procedures. In addition, documentation of the staff who participated in the fire drill or staff training documentation on fire drill procedures on the third shift for the second quarter 2022 was also not available for review. Documentation for the third shift fire drill conducted on 06/13/22 at 5:00 a.m. did not include documentation of the staff who participated in the fire drill or drill procedures. Based on interview at the time of record review, the Maintenance Supervisor stated the facility operates three shifts per day and agreed documentation of staff who participated in the fire drills or staff training on fire drill procedures for the aforementioned shifts and quarters in 2022 was not available for review. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference.		recur.1. The Maintenance Director/designee will complete an audit quarterly to ensure that the facility has fire drills conducted per regulation.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff.2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined.5. Date of Compliance: 8-12-2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	3.1-19(b)			
K 0741 SS=D Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on record review, observation and interview; the facility failed to ensure smoking materials were deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible	K 0741	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of**	08/12/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

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	material and safe design in 1 of 2 outdoor areas where smoking was taking place. This deficient practice could affect over 2 staff and visitors in the vicinity of the outdoor staff smoking area at the kitchen exit door to the outside of the facility. Findings include: Based on review of "Smoking" policy documentation with the Maintenance Supervisor during record review from 9:40 a.m. to 12:50 p.m. on 07/25/22, assessed residents and staff are allowed to smoke in designated outdoor smoking areas. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:30 p.m. on 07/25/22, well over 50 cigarette butts were deposited into an open top metal coffee can outside the facility at the kitchen exit door to the outside of the facility on the southwest side of the building. Ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design were not provided at this outdoor location where staff smoking was taking place. Based on interview at the time of the observations, the Maintenance Supervisor stated the coffee can with the extinguished cigarette butts has been there for quite a while but agreed cigarette butts were not deposited into the ashtrays and metal containers with self-closing cover devices at this outdoor location where staff smoking was taking place. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of correction. The provider alleges compliance as of 8/12/22** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. All residents have the potential to be affected by the alleged deficient practice. All cigarette butts were appropriately disposed of in a metal or non-combustible container with a self-closing cover device. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by the alleged deficient practice. All cigarette butts were appropriately disposed of in a metal or non-combustible container with a self-closing cover device.	

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			2. A campus wide audit of the facility grounds was completed to eliminate all cigarette butts were properly disposed of. 3. The Maintenance Director was educated on the need to have all cigarette butts appropriately disposed of in a metal or non-combustible container with a self-closing cover device. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The Maintenance Director/designee will complete an audit 5 times a week for 3 months to ensure all cigarette butts were properly disposed of. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined.	

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			5. Date of Compliance: 8-12-2022	
K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panels was in proper operating condition. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:30 p.m. on 07/25/22, the "not in auto" status indicator light for the wall mounted remote annunciator panel located at the C Hall nurse's station was illuminated indicating system trouble. Based on interview at the time of the observations, the Maintenance Supervisor stated he was not aware of any generator issues and stated the emergency generator would start if the building were to lose power but agreed the "not in auto" status indicator light for the wall mounted	K 0916	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of correction. The provider alleges compliance as of 8/12/22** 1. What corrective action(s) will be accomplished for those residents found to have been	08/12/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	remote annunciator panel was illuminated. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		affected by the deficient practice. 1. All residents have the potential to be affected by the alleged deficient practice. The facility corrected the concern with the “not in auto” status indicator light for the wall mounted remote annunciator panel located at the C hall nurse’s station, the light is no longer illuminated. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. Education was provided to the Maintenance Director of the regulation of regarding remote annunciator related to generator functionality and operations 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. The Maintenance Director or designee will complete audits 5 times a week for 3 months during campus rounding to ensure annunciator is properly functioning and in compliance with state and	

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			federal regulations 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-12-2022	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a			

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	155665	A. BUILDING 01 B. WING	07/26/2022

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	year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to document emergency generator monthly load testing for 6 months of the most recent 12-month period to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of	K 0918	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of correction. The provider alleges compliance as of 8/12/22**1. 1. What corrective action(s) will be accomplished for those residents found to have been	08/12/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/26/2022

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	8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generators: Test Generator Under Load" documentation for the most recent twelve-month period with the Maintenance Supervisor during record review from 9:40 a.m. to 12:50 p.m. on 07/25/22, monthly load testing documentation for the facility's diesel fired emergency generator for the six-month period of August 2021 through January 2022 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated he started working at the facility earlier in 2022 and agreed monthly load testing documentation for the aforementioned six-month period was not available for review. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the emergency generator set was maintained for 31 weeks of the most recent 52-week period. This deficient practice could		affected by the deficient practice. 1. All residents have the potential to be affected by the alleged deficient practice. Facility generator has been tested “under load” and” with no load”. Facility generator met requirements during testing 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. The Maintenance Director was educated on the regulation of all facility generator testing and documenting in TELs 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The Maintenance Director/designee will audit weekly that all documentation and testing of the facility generator is completed in accordance with state and federal regulations 4. How the corrective action(s) will be monitored to ensure the	

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	affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Generators: Exercise Generator (with no load)" documentation with the Maintenance Supervisor during record review from 9:40 a.m. to 12:50 p.m. on 07/25/22, weekly inspection documentation for the facility's diesel fired emergency generator for the 31-week period of 08/21/21 through 03/25/22 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated he started working at the facility earlier in 2022 and agreed weekly generator inspection documentation for the aforementioned 31-week period was not available for review. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. For quality assurance, the Maintenance Director/designee will review any findings yearly, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-12-2022	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE			

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	155665	A. BUILDING 01 B. WING	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

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	meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on record review, observation and interview; the facility failed to ensure 3 of 3 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not	K 0920	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of correction. The provider alleges compliance as of 8/12/22** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. The rooms/offices found to be of concern during the survey	08/12/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/26/2022

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	commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on review of "Electrical Safety for Residents" policy documentation dated 12/17/20 with the Maintenance Supervisor during record review from 9:40 a.m. to 12:50 p.m. on 07/25/22, the "Extension cords shall not be used as a substitute for adequate wiring in the facility". In addition, the policy stated "Power strips shall not be used as a substitute for adequate electrical outlets in the facility. Power strips may be used for a computer, monitor and printer". The policy also stated, "Power strips shall not be used with medical devices in resident-care areas". in lieu of permanent wiring is prohibited". Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:30 p.m. on 07/25/22, a cell phone charging cable was plugged into a power strip placed on the floor under the head of the resident bed nearest the corridor door in resident Room C110. The UL listing of the power strip could not be determined. A cell phone charging cable was plugged into a power strip placed on the floor of the C Hall nurse's office. An operating fan was plugged into an extension cord in the water softener room near the kitchen. Based on interview at the time of the observations, the Maintenance Supervisor stated he had to install the fan in the water softener room within the last week as the room was excessively hot but agreed a power strip was being used in the patient care vicinity in Room C110 and extension cords were being used as a substitute for fixed wiring at the aforementioned locations.		has had the power strips removed. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All residents, staff, and visitors have the potential to be affected by this practice 2. A campus wide audit was completed to ensure that only approved power strips are being used and no multi-plug adapters in the laundry areas. 3. The Maintenance Director was educated on the regulation of only approved power strips to be used in the facility and no multi-plug adapters in the laundry areas. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. The Maintenance Director/designee will conduct audits 5 times a week for 3 months during facility rounding to ensure only approved power stripes are in use throughout the facility 4. How the corrective action(s)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

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	This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-12-2022	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a			

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	minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 storage locations of nonflammable gases equal to or greater than 3000 cubic feet were secured against unauthorized entry. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2.1 states storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by the kitchen.	K 0923	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. The provider respectfully requests that State Report Plan of Corrections be considerered the Letter of Credible Allegation & request a desk review regarding plan of correction. The provider alleges compliance as of 8/12/22**	08/12/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 01 B. WING	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

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	Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:30 p.m. on 07/25/22, the corridor entry door to the oxygen storage and transfilling room near the kitchen was equipped with a keypad lock on the door to secure the door against unauthorized entry. However, the keypad lock was not functioning properly and did not lock the door. In addition, the latching mechanism for the corridor door failed to latch the door into the door frame when tested to close multiple times. The room contained four liquid oxygen containers and seventeen 'E' type oxygen cylinders. Based on interview at the time of the observations, the Maintenance Supervisor agreed the corridor entry door to the oxygen storage and transfilling room was not locked to secure against unauthorized entry and failed to latch into the door frame. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. All residents have the potential to be affected by the alleged deficient practice2. The keypad was repaired to be in working condition and the locking mechanism on the door was repaired to, so it latches in accordance with state and federal regulations 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.1. All Residents have the potential to be affected by this practice.2. Education was provided to the Maintenance Director of the regulation of having nonflammable gases equal to or greater than 3000 cubic square feet secured against unauthorized entry. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.1. The Maintenance Director/designee will identified areas are protector against unauthorized entry by conducting audits 5 times a week for 3 months during facility rounding4. How the corrective action(s) will be monitored to ensure the deficient practice will	

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			not recur, i.e., what quality assurance program will be put into place.1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff.2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined.5. Date of Compliance: 8-12-2022	